

HIV/AIDS Orphans and NGOs in Zambia:
Strategy Development for Programming
by the USAID/Zambia Mission for Family and
Community Care of Children Affected by HIV/AIDS

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LIST OF ACRONYMS AND ABBREVIATIONS

ASO	AIDS Service Organization
CA	Contracting Agency
CBO	Community Based Organization
CHIN	Children in Need
CINDI	Children in Distress Project
CMAZ	Christian Medical Association of Zambia
DHMT	Distress Health Management Team
FHT	Family Health Trust
GOZ	Government of Zambia
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
MSE	Micro and Small Enterprise
NASTLP	National AIDS, Sexually Transmitted Infection, Tuberculosis, Leprosy Program
NGO	Nongovernmental Organization
PCI	Project Concern International
PHN	Population, Health and Nutrition
PWA	Public Welfare Assistance
RFA	Request For Application
SIDA	Swedish International Development Agency
SKI	Street Kids International
STI	Sexually Transmitted Infection
SWAAZ	Society For Women and AIDS in Zambia
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
ZHIP	Zambian Integrated Health Policy
ZNFE	Zambian National Federation of Employees
ZNFU	Zambian National Farmers Union

I. OBJECTIVES OF THE CONSULTANCY

The six objectives for the consultancy, “HIV/AIDS Orphans and NGOs in Zambia,” were as follows:

1. Report on the current situation of HIV/AIDS in Zambia and the situation of families and children affected by AIDS.
2. Assess the sufficiency of data on HIV/AIDS-affected children and families in Zambia to determine if a Request for Application(RFA) can be written or if more studies are needed.
3. Examine the role of economic activities in ensuring the sustainability of community-based programs for families and children affected by HIV/AIDS.
4. Examine the contribution of income-generating activities to individual and family coping strategies.
5. Describe criteria for the incorporation of programs for families and children affected by AIDS in USAID’s Zambia Integrated Health Package (ZIHP).
6. Suggest alternative implementation mechanisms for USAID programs for families and children affected by AIDS in Zambia.

These initial objectives were revised and expanded in discussion with the Mission Population, Health and Nutrition (PHN) Team at the beginning of the consultancy for the following reasons:

1. To respond more explicitly to the Mission’s need for material relevant to the development of a long-term RFA for Health.
2. To enable the Mission, in the interim, to access funds from USAID’s Displaced Children and Orphans Fund (DCOF) as quickly as possible for interim experimental activities in family and community care.
3. To better articulate the relationship between the provision of family and community care and economic ability.
4. To represent more completely both the Missions and the DCOF’s purpose for the engagement.

II. SPECIFIC ACTIVITIES AND TASKS

The Scope of Work specified a number of activities to be conducted in Zambia to fulfill the objectives of the consultancy:

1. Collect the most recent HIV seroprevalence data from the National AIDS, STI and Leprosy Control Program and discuss projections of future trends with epidemiologic staff.
2. Review orphan data and projections from NACP, the National Statistics Office, the Demographic and Health Survey, and other sources and determine future plans for data collection.
3. Meet with officials from the Ministry of Health and other relevant ministries (for example, Community Development and Social Welfare) to discuss the current situation, programmatic activities and planned policy responses.
4. Meet with representatives of UNICEF, UNAIDS, UNDP, and other relevant UN agencies to discuss the current situation, programmatic activities and planned policy responses.
5. Meet with representatives of NGOs (for example, PCI, CINDI, CHIN, CARE) and CBOs that are administering programs for families and children affected by AIDS and street children programs or that are developing community-based income-generating and economic activities.
6. Assess the current situation of orphanages, including current and anticipated role in the protection of vulnerable children, supply, policy and administration.
7. Discuss psychosocial issues of HIV/AIDS-affected children and families with Alan Haworth and other researchers active in the field (for example, Webb, Serpell).
8. Review the USAID Zambia Integrated Health Package and discuss it with Mission officers to determine how activities for families and children affected by HIV/AIDS could be integrated with the Mission's current and anticipated programs in HIV/AIDS, family planning, and maternal and child health. Discuss alternative implementation mechanisms for expanded programs for families and children affected by HIV/AIDS.
9. Review the USAID-funded HIV/AIDS program of Project Concern International to determine current approaches.
10. Visit the Pediatric Unit of the University Teaching Hospital of Zambia to determine current programming efforts.

11. If possible, research the responses undertaken by private, for-profit companies to assist families and children affected by HIV/AIDS (for example, Zambian National Farmers Union, Lonrho, Zambian Council of Industries).

All of these tasks were accomplished with three exceptions:

1. The consultants did not visit the University Teaching Hospital Pediatric Unit because it was impossible to schedule a time convenient for the unit. However, the consultants conferred briefly with Dr. Nkanda Luo, Chief of Pediatrics, and other community members about the functioning of the unit and the related home health care team.

2. The consultants did not visit with Professor Alan Haworth because they believed it was more appropriate to interview researchers who were currently investigating the situation of families and children affected by HIV/AIDS. Professor Haworth's last published contribution to the field was in 1991, and it had been reviewed in summary articles.

3. The consultants were unable to visit with the Street Kids International (SKI) director but did interview the former director, who became head of the CBO network, CHIN (Children in Need), in 1996. SKI's director was invited to the presentation/focus group given by one of the consultants, but he did not attend.

In addition to the scope of activities, one of the consultants (Susan Hunter) presented USAID's special report, "Developing Strategies and Policies for Support of HIV/AIDS Infected and Affected Children," to a group of concerned NGOs, CBOs, and ministry personnel at a meeting at the Central Board of Health. The presentation was arranged by the Mission to raise awareness of the need for urgent policy and programmatic response for children and families affected by HIV/AIDS in Zambia. This provided an opportunity to conduct a short focus group with many CBO heads with whom the consultants were unable to meet individually.

III. DATA COLLECTION

Data collection for the consultancy occurred between June 5, 1997, and June 12, 1997. Interviews were held with 53 individuals representing 31 governmental and nongovernmental organizations involved in HIV/AIDS prevention and care activities and in income-generation and the development of economic activities that might potentially benefit families and children affected by HIV/AIDS. These are summarized in Appendix 1. There was a good deal of overlap in the target populations of the AIDS service organizations and the income-generation groups. Most AIDS service organizations are attempting to create opportunities for income generation to support their charitable activities, and groups that focus on income generation and community development are comprised of many households affected by HIV/AIDS. This is discussed further below.

The consultants conducted four brief site visits to existing projects and community-based organizations in Lusaka, including Tashinta, the Bauleni Compound Society for Women and AIDS in Africa project (with the Deputy Minister of Health, Professor Nkanda Luo), families served by CINDI (Children in Distress), and CARE's community development project. During these site visits, interviews were also conducted with family members and children as well as with project staff (see Appendix 1).

One of the consultants had assisted earlier as part of the Zambia Mission's HIV/AIDS Redesign Team in June 1995. In that capacity, she made a site visit during the present consultancy to review community-based responses in Ndola District. In addition, through work with UNICEF/Zambia in 1991 for strategy development for HIV/AIDS affected families, she assisted several NGOs in formative data collection.

The consultants' presentation at the Zambian Central Board of Health was used as an opportunity to collect data and discuss the strategies that had been recommended in the report and developed during the earlier Zambian interviews. A list of attendees is included in Appendix 1.

Finally, the consultants reviewed a variety of documents and literature on AIDS epidemiology, prevention and mitigation efforts, the situation of families, and economic activities in Zambia. These are listed in Appendix 2.

IV. FINDINGS

HIV/AIDS Infection Levels

The HIV/AIDS epidemic in Zambia is one of the worst in Sub-Saharan Africa. The most recent national seroprevalence survey (NASTLP, 1994) revealed an urban infection rate of 28.2 percent among women of childbearing age and a rural infection rate of 12.9 percent among the same population. Although a 1996 survey using saliva testing may have demonstrated a slight decline in prevalence among young urbanites (aged 15-19) in one location, the overall results of this survey were similar to those of the 1994 serosurvey, shown in the table below.

**HIV/AIDS Infection Rates in Zambia by Age Group
and Geographic Region**

Age Group	<u>Infection Rate</u>					
	<u>Urban</u>		<u>Periurban</u>		<u>Rural</u>	
	Males	Females	Males	Females	Males	Females
15-39	18.3	29.7	25.6	38.2	16.2	17.2
15+	21.6	29.0	26.5	34.5	14.4	16.5

The results suggest that there are two parallel epidemics in Zambia, an urban/periurban epidemic and a rural epidemic. Responses, both donor-funded and community-based, reflect this division (see discussion below). The fact that rural infection rates are higher than the overall infection rates of many other countries in Sub-Saharan Africa suggests that rural communities in Zambia deserve greater attention than they have received. In addition, significant institutional communities with rural as well as urban bases including the military and selected mining and industrial and commercial farming communities, are not represented in these samples.

According to estimates by the U.S. Census Bureau (1996), increased infant, child and adult mortality from AIDS will reduce population growth in Zambia to almost zero by 2010 and adversely impact a variety of other mortality and morbidity indicators. The total direct and indirect (fertility related) population loss will reach 4.2 million, the average life expectancy will drop to 30.3 years, infant mortality will rise to 97.4, child mortality will rise to 202.1 deaths per 1000 births, and the fertility rate will increase to 5.4.

These estimates were made using serosurvey data from the National AIDS/STD/TB and Leprosy Programme (NASTLP) and data from smaller research initiatives in Zambia that the U.S. Census Bureau's International Programs Division updates regularly. They are corroborated by household data from UNICEF/Zambia-sponsored research and other sources.

Epidemiologists and NASTLP staff are currently working to determine if the data from the 1996 saliva survey suggest that the epidemic has peaked among certain age groups and in certain locations. This debate may not be resolved until a new round of serosurvey data is collected by the NASTLP. In the meantime, U.S. Census Bureau sources project that the epidemic for the country as a whole will peak some time after 2000, possibly as late as 2005. Other sources in Zambia, including the NASTLP-published projections, agree with the Census Bureau estimate. This implies that rates of orphaning will not peak until after 2010, because there is typically a seven-to-10 year lag between the seroprevalence and orphaning peaks.

Social and Economic Impact

Many of the social and economic impacts of the HIV/AIDS epidemic have been analyzed in the Zambian context (Webb, 1996); they are summarized in the box below. These impacts will combine to reduce the ability of donor agencies to effectively carry out their missions and achieve their targets in all sectors, most conspicuously in the health sector. UNICEF/Zambia has estimated that increases in infant and child mortality will be even more severe than the U.S. Census Bureau predicts. Programming is made even more difficult by the loss of key staff and line health sector personnel.

UN agencies have explicitly incorporated the impact of AIDS into their individual country work programs in all sectors, and they provide active AIDS prevention and care services in their personnel benefit packages. UNICEF/Zambia's current country program includes specific activities for prevention and care in the health, education and vulnerable children components. UNDP has arranged for UN Volunteers to work with vulnerable communities in the Southern Province of Zambia.

Anticipated Social and Economic Impacts of HIV/AIDS in Zambia

Economic/Private Sector

- Increased Mortality of Skilled Personnel
- Reduced Productive Capacity of Non-Skilled Personnel
- Reduced Agricultural Productivity
 - Subsistence
 - Export
- Reduced Numbers of Active Consumers
- Reduce Savings and Investment
- Increased Downward Spiral into Destitution of Poor Households

Health Sector

- Reduced Life Expectancy
- Increased Infant and Child Mortality
- Lower Dependency Ratios
- Individual and Social Demoralization
- Increasing Orphan Burden
 - More Households in Poverty
 - Reduced Education and Training
- Loss of Key Line and Staff Personnel
- Clogging of Health Facilities with AIDS-Related Patients
- Reduction in Availability of Services for Other Diseases and Conditions
- Increased Prevalence of Other Diseases, especially TB

Education Sector

- Reduced Supply of Teachers
- Declining Ability of Families to Pay School Fees
- Decline in School Enrollment

Social Sector

- Disruption of Large Numbers of Displaced Children
- Increased Migration of Displaced Families and Children

Rates of Orphaning

In Zambia, an orphan is defined as a child who is missing one or both parents. Most sources use a cut off age of 15, although some estimates include all children under age 18. Projections of the total number of orphans for the year 2000 from AIDS and other causes range between 450,000 (UNICEF) and 600,000 (NASTLP). NASTLP has estimated the total for 2000

as 600,000 but indicates that the number of AIDS deaths is likely to double between 1994 and 2000. Such a doubling would triple the total estimate to 1.8 million orphans. The estimates of Zambia's orphan population from AIDS and other causes (under 15 years of age), as shown in the table below (Hunter and Williamson, 1997).

Number of Orphans

	2000	2005	2010
Maternal and Double	745,492	968,786	1,145,892
Paternal	911,157	968,786	937,548
Total	1,656,649	1,937,572	2,083,440

These estimates are consistent with the high-end estimates of the NASTLP, which include only HIV negative children.

Comparison of NASTLP and Study Projections -- 2000

	NASTLP	US CB
Maternal and Double AIDS Orphans	No projection	584,447
Maternal and Double Orphans Due to Other Causes	No projection	161,015
Total Maternal and Double Orphans	No projection	745,492
Paternal Orphans	No projection	911,157
Total Orphans	530,000 to 600,000*	1,656,649

* The NASTLP state that the actual numbers of orphans may be as much as three times higher than they have estimated, that is 1,590,000 to 1,800,000.

Household survey data suggest that the higher NASTLP estimate of 1.8 million orphans and the U.S. Census Bureau estimate of 1.7 million orphans better represent the current reality in Zambia. In his 1996 national sample survey of households, McNerrow (1996) found that 72 percent of households included orphans and that 54 percent of the children in the sample had lost one or both parents. He estimated the total number of orphans at 2 million. His findings represent a virtual doubling of the estimates made only five years earlier by Mulenga (1993).

The U.S. Census Bureau has compared the proportion of Zambian children under age 15 who will be orphans in 2000 with the proportion of orphans expected in neighboring countries as shown in the table below.

Prevalence of Orphans in Zambia and Other Southern African Countries, 2000

Country	Maternal Orphans as a Percentage of Children < 15	AIDS Orphans as a Percentage of All Orphans
Zambia	15.4	78.4
Malawi	12.3	69.5
Zimbabwe	12.3	84.7
Botswana	10.5	70.6
South Africa	5.2	60.9

Source: US Census Bureau

Distribution of Orphans by Type and Residence

The breakdown of orphans by type in Zambia is estimated as shown in the table below.

Distribution of Orphans in Zambia

Source	<u>Type as a Percentage of All Orphans</u>		
	Maternal Orphans	Paternal Orphans	Double Orphans
US Census Bureau	25.0	55.0	20.0
McNerrow, 1996	10.7	66.6	22.6
Webb, 1996	18.0	53.9	28.1

Studies in other countries have demonstrated that maternal (mother dead) and double orphans (both parents dead) under 5 years of age are at higher risk for sickness and are less likely to receive immunizations. Paternal orphans (father dead) of school age are at greater risk of receiving little or no schooling. Double orphans are potentially the most vulnerable. However, maternal orphans left with little or no resources following the death of their father will also face serious disadvantages.

Studies in Zambia suggest that there is little difference in the treatment of maternal, paternal and double orphans. However, more work may be necessary to determine if this is the case. In addition, the treatment of orphans may deteriorate in comparison with that of other children in a household as caretakers assume additional children and households become more impoverished.

Data on the prevalence of orphans by geographic area from the 1996 Zambia Living Conditions Monitoring Survey are shown in the table below. A total of 549,024 households were interviewed for the survey.

Distribution of Orphans by Geographic Area, Zambia, 1996					
Geographic Area	Number of Children <18	% of Children < 18 Orphaned	Type of Orphan as a Percentage of All Orphans		
			Maternal	Paternal	Double
<u>Province</u>					
Central	388,622	13	23	67	11
Copperbelt	741,154	12	18	65	18
Eastern	524,895	11	24	66	10
Luapula	373,108	14	23	61	16
Lusaka	484,717	17	18	63	19
Northern	585,116	12	18	72	10
Northwestern	220,559	11	23	69	8
Southern	617,797	13	27	60	13
Western	254,577	17	28	56	16
Urban	201,561	15	18	65	17
Rural	347,463	12	24	64	12

It appears that the provincial numbers were computed by multiplying the provincial proportions (column 2) times the total provincial population. If these provincial estimates are totaled, the national estimate is 4,739,569. Unfortunately, the consultants were unable to clarify the discrepancies with the Central Statistical Office. However, it may be possible for the Mission staff to inquire. Such data would provide an important new source of estimates for discussion with the NASTLP and other interested parties.

The survey demonstrates that the rate of orphaning is slightly higher in urban areas than in rural areas, as would be anticipated from the serodata. It also demonstrates important differences between provinces. In areas where the epidemic is more advanced (urban areas, Lusaka and Copperbelt Provinces), the proportion of double orphans is increasing because sufficient time has elapsed for both parents to die. In areas where the epidemic is less advanced (rural areas, Eastern, Northern, Northwestern and Western Provinces), the proportion of double orphans is lower. These differences have important implications for staging programs geographically and programmatically. They also suggest that monitoring and evaluation by geographic area might reveal important geographic differences in family and community coping strategies over time.

Orphan Living Arrangements

Recent small area survey data show that although nearly half of the guardians of paternal orphans are their mothers, surviving fathers are unlikely to be guardians (6.3 percent in one national survey, 4.3 percent in a second). Almost all maternal orphans are cared for by relatives other than the orphan's father. Two 1996 surveys, one national and one confined to Lusaka, revealed the caretaker arrangements as shown in the table below.

Guardianship Arrangements for Zambian Orphans, 1996
Results of Two Surveys

Guardian	Percentage of Orphans			
	McKerrow Survey	Webb/Nkamba Survey	Serpell Chikankata	Lusaka
Surviving parent	50.2	45.5	26	63
Grandparent	27.3	28.3	57	23
Extended family member	15.6	19.6	14	10
Elder sibling	5.0	5.6	3	4
Unrelated	1.9	1.0	0	0

Over time, as more adults die, fewer children will have a surviving parent on whom they can depend. In addition, grandparents will age and die, so more children probably will end up in the care of other extended family members or will decide to care for themselves. McKerrow reports that almost one-third of the families he surveyed in his national study expected to provide care for orphans within the immediate family. However, a significant proportion expected state assistance or that the government would provide shelter.

Orphan Placement Arrangements Preferred by Zambian Families

Immediate family	31.2%
Extended family	12.0%
Friends	2.2%
Community	7.9%
State	13.8%
Other	4.3%
Don't know	28.7%

Unwilling to separate siblings 92.7%

Stay in their own house	63.1%
Within their community	24.7%

Source: McKerrow, 1996

While the overwhelming majority of the Zambian families McKerrow surveyed said they would prefer to shelter the children within their own house or community, 48.9 percent said they expected that day-to-day care would be provided by an orphanage. Presumably, some type of collective day care is implied.

Currently, only a small proportion of orphaned children are cared for in orphanages (residential facilities providing complete care for children), although there is also a proliferation of informal orphanages. Historically, orphanages were established to care for motherless children until the age of three, when the child's father or an extended family member was expected to care for the child in the home. During the second Republic, only the country's largest orphanage, Kasisi in Lusaka, was kept open. This measure was taken to encourage extended family members to assume responsibility for care.

One respondent indicated that there are 15 officially recognized orphanages in Lusaka and at least 15 others that are unlicensed. It is not known if the latter are residential orphanages or merely day centers. Child care is provided in child care centers or day centers by several NGO groups, and these are sometimes referred to as orphanages or children's homes. One of the founders of Kwasha Makwenu indicated that their day center cares for nearly 1,000 children. It was not possible to verify these numbers during this consultancy, but official capacity should be known by the Social Welfare Department of the Ministry of Community Development and Social Services.

Our estimate is that the current capacity in official facilities does not exceed 9,000 children (30 facilities multiplied by 300 children per facility) and is probably closer to 5,000. Capacity in all the country's child care centers probably ranges between 3,000 and 5,000. While these numbers need verification, capacity would meet the need of only .05 percent of the 1.6 HIV negative children who are currently orphaned in the country.

Some proportion of children, estimated at 70,000 in Lusaka in 1991, are living and/or working on the streets. No recent estimates of this population have been made, and no figures were cited in the literature for other large urban areas. Street Kids International may have some more current data, but other informants were unaware of any more recent estimates.

It is possible to estimate the number of orphans who are in alternative living arrangements using this data. However, there may be some overlapping in the categories because some street children are not orphans but working in the streets, and many children in residential orphanages are HIV+ and are not included in the Census Bureau total of 1.7 million orphans in Zambia. Despite these limitations, these estimates give a clear picture of where the current burden of care is being borne:

Estimated Number of Zambian Orphans in Alternative Living Arrangements, 1996

Living Situation	Number of Orphans	Percentage of Total
Orphanages	5,000 - 9,000	.03 -.05
Living/working on the street	70,000 - 150,000	4.2 -6.7
Individual caretakers (families, neighbors)	1,547,000	95.8 -93.25

Estimates of HIV+ Children

Although it is possible to estimate the number of HIV+ children who will be born to Zambian mothers between now and 2010, an adequate methodology for estimating the number of HIV+ children who will be in need of care at any point in time within these intervals has not been developed. The estimated total mortality rate of females and seroconversion rates for infants infected in utero offer some indication. Infected infants are likely to die within two years of birth and to require considerable care while alive. Experiments with vitamin A therapy for infected mothers and children seem to show positive results in reducing the seroconversion of HIV+ newborns. However, for this therapy to be effective, HIV+ mothers and infants must be identified, which requires that a number of operational constraints be overcome, including resistance to widespread HIV/AIDS testing in Zambia.

Obtaining an accurate picture of the size of this population of children would help in estimating the need/demand for institutional placement, because these are the children most frequently placed in institutions or abandoned. A second group of children, those born to commercial sex workers, are also difficult to place regardless of whether they are seropositive or seronegative, because they often have no extended family ties.

Needs of Orphans

The needs of orphans are the needs of households in poverty (food, shelter, bedding, clothing), the needs of children generally under age 15 (health, schooling), and the needs of children aged 15 and above (access to work). A consistent picture emerges from Zambian data, which is corroborated by data from other Sub-Saharan African countries. School-aged orphans have higher rates of nonenrollment than nonorphans. In urban areas, 32 percent of orphans are not enrolled in school compared with 25 percent of nonorphans; in rural areas, 68 percent of orphans are not enrolled, compared with 48 percent of nonorphans (Rossi and Reijer, 1995; Webb, 1996). Other types of discrimination in treatment between orphans and nonorphans are not detected in Zambian surveys (Poulter, 1996; McKerrow, 1996).

Socioeconomic Status of Households

The proportion of households in poverty, according to official estimates, ranges between 60 and 70 percent. The 1996 Zambian Living Conditions Monitoring Survey showed that a large number of Zambian households are living in extreme poverty. Fifty-five percent of all households reported starvation during the past 12 months, and starvation was even more prevalent in female-headed households and in rural households.

Zambian Households Reporting Starvation or Very Little to Eat in 1996

Type/Residence	Proportion Reporting Starvation	Of Those Reporting Starvation, Proportion for More than One Week
Male-headed households	53	56
Female-headed households	61	64
Urban	48	49
Rural	58	51
Countrywide	55	58

Some 41 percent of all Zambian households report that they are very poor, while 51 percent report that they are moderately poor. Self-assessed poverty is higher in female-headed households, which were also more likely to report that their living conditions had deteriorated in the past 12 months. Forty-five percent of all Zambian households said their living conditions had deteriorated in the year prior to the survey (1996). Almost twice as many rural as urban households said they were very poor, while more urban households reported being moderately poor. Despite these differences in perception, urban to rural migration was slightly higher (15 percent) than rural to urban migration (7 percent).

Sixty-eight percent of the Zambian population aged 12 and above is in the labor force. Labor force participation for both males and females aged 12-19 is highest in rural areas and increases dramatically for all groups above age 19 except urban females. Some 76 percent of workers are in the informal sector. The rural informal sector accounts for a larger proportion of workers (85 percent) than the urban (49 percent) because the category includes subsistence farmers. Unemployment rates are high in urban areas, especially among youths aged 12-24, about 60 to 70 percent of whom are unemployed.

Access of Households to Services

One-quarter of interviewees in the 1996 Zambian Living Conditions Monitoring Survey reported having an illness in the two weeks prior to the survey, and 42 percent of this group sought treatment. Of those seeking treatment, three-quarters sought help at a government institution. Rural and urban care-seeking patterns differed slightly: 13 percent of rural residents sought care from mission facilities, while 11 percent of urban residents sought care from industrial sources. A small proportion of urban residents (8 percent) sought care from a private source, four times as many as in rural areas. Traditional sources were four times as popular in rural areas (4 percent) as in urban areas.

Approximately two-thirds of all school-aged children attend school. Attendance rates are higher for males than females at the secondary school level, and overall attendance rates are higher in urban populations, especially after grade 7. School attainment is higher in urban areas than in rural areas, where enrollment drops dramatically after primary school.

Access to primary school facilities (within 5 kilometers) is about equal in urban and rural areas, but access to secondary schools is much greater in urban areas. A large proportion of rural residents (48 percent) are more than 5 kilometers from the nearest health facility, while no urban residents are more than 5 kilometers from health services.

The majority (65 percent) of Zambians believe boys should be given priority in schooling, compared with 5 percent who say girls should have priority. This bias is much stronger in rural areas (71 percent compared with 55 percent) and about equal between males and females, but it diminishes with increased education.

An estimated 95 percent of all Zambian households are within 1 kilometer of their main source of water, but access for urban households is much greater. Rural residents are much more likely to use unprotected sources (69 percent) than urban residents (12 percent) but less likely to treat or boil their drinking water.

Household Coping Strategies

According to the 1996 Zambian Living Conditions Monitoring Survey, most households rely on other households for support, with about half giving and half getting support. Male-headed households are more likely to give support than female-headed households, and urban households more likely to give support than rural households.

Proportion of Households Receiving and Giving Assistance to Other Households, 1996

Type/Residence	Percentage of Households Receiving Assistance	Percentage of Households Giving Assistance
Male-headed households	51	62
Female-headed households	59	47
Urban	47	62
Rural	56	57
Countrywide	53	59

Note: Proportions may exceed 100% in a category because some households both give and receive assistance.

Households rely extensively on the labor of children aged 5 to 11 years for cleaning, food preparation, child care for siblings, gathering food and firewood, carrying water, and farming tasks (Living Conditions Monitoring Survey, 1996). Girls are two to three times more likely than boys to be required to do household chores, with the exception of farming activities, gathering and chopping firewood, tending livestock and hunting. Few young children attend to the sick (6 percent of boys and 8 percent of girls), although rural children are twice as likely to provide such help.

Three percent of children between 6 and 11 years of age were engaged in some kind of income-generating activity. There was little difference between boys and girls or between urban and rural children.

Violence against women is condoned. Some 31 percent of all Zambians believe a man is entitled to beat his wife. This variable shows the same variation as beliefs about gender priorities

in schooling.

Other important coping strategies for households include borrowing, reducing food intake, and begging from friends. Reliance on charity assistance is very low.

Proportion of Zambian Households Using Various Coping Strategies, 1996

Strategy	Urban Households	Rural Households	Countrywide
<u>Food Strategies</u>			
Reducing Food Intake	52	58	56
Substituting Snacks for Meals	32	58	41
Eating only Wild Food	2	14	10
Obtaining Relief Food	9	2	6
<u>Expense-Reducing Strategies</u>			
Other Household Purchases	46	48	47
Pulling Children Out of School	4	4	4
<u>Doing Additional Work</u>			
Piecework on Farms	6	30	23
Other Piecework	16	21	21
Exchanging Work for Food	4	30	22
<u>Selling Assets</u>	9	12	11
<u>Borrowing</u>			
Formal	8	5	6
Informal	32	18	23
<u>Charity</u>			
Church	3	4	4
NGO	1	3	2
<u>Begging</u>			
From Friends	31	29	30
On the Street	0	1	1

Res

ponse at the Family, Household, and Community Levels

The proportion of households with orphans has increased rapidly since the beginning of the decade:

Proportion of Zambian Households Caring for Orphans		
Researcher	Date	Proportion
Mulenga	1993	37%
McNerrow	1996	72%

About one in 10 Zambian households had experienced at least one death during the 12 months preceding the Zambian Living Conditions Survey in 1996, with little difference between urban and rural households. The proportion of households caring for a chronically ill person was estimated at 6.5 percent in 1995 (Sichone et al., 1995). The same national survey also showed that most patients and caregivers preferred home care to hospital care. In a nation where hospitals are overburdened with AIDS-related cases, this finding is very positive. Unfortunately, however, access to outside sources of assistance was reported as being low, and patients and caregivers were dissatisfied with the quality of care being provided at home, as shown in the following table.

**Problems Experienced and Sources of Support
for Immediate Caregivers of Terminally Ill Patients,
Zambia, 1995**

Problem/Source	Proportion Reporting
<u>Problem</u>	
Food	71
Water	28
Clothing	8
Drugs	9
Money	22
No Problems	9
<u>Sources of Support</u>	
Relatives	48
Friends	34
Churches	21
Home-Based Care Program	0
<u>Preference for Home Care</u>	
Patients	77
Immediate Care Providers	71
Home Care Patients Reporting Their Care is Inadequate	73
Ever Heard of Home-Based Care Program	16
Ever Been Visited	4

The situation for families caring for orphaned children is similar. The majority of orphans are cared for within families, and the majority of Zambians preferred to take care of orphans within the family, but were afraid because of economic limitations that they would not be able to (Webb, 1996). Access to a variety of sources of support, most of it from family members neighbors, friends and other community members, is reported by families caring for orphaned children.

**Sources of Support for Zambian Households Caring for Orphaned Children,
1996**

Source	Proportion of Households Receiving Support
Family	47.4
Friends and neighbors	12.3
Community	3.4
Church	8.8
State	2.2
Other	14.9
None	11.0

Source: McKerrow, 1996

But while almost half of all families caring for orphans receive support from family members, many families use the opportunity of an illness or death to take advantage of their relatives. Many individuals interviewed by the consultants reported that “property grabbing,” when in-laws remove all or some of a widow’s property following the death of a spouse, is a common practice. Widows’ legal rights to inheritance are often violated, and they are left impoverished. The director of the YWCA’s Legal Aid Initiative reported that most Zambian women are unaware of their legal rights, and a majority of Lusaka judges who review such cases are unfamiliar with estate law.

Trends to nuclearization of family responsibility in both urban and rural settings were reported by informants, who said that families are forming new, surrogate or informal “extended families” (with neighbors and friends) to replace assistance from the extended family. These trends are stimulated by poverty, which leaves more and more Zambians with the perception that they have little to give and much to gain and that any occurrence can be turned into an opportunity for betterment.

Families report that they seek out and receive a wide variety of informal support from their families, neighbors and friends. Support varied widely among the four communities included in the study, due largely to differences in economic circumstances. Persons planning support services need to review the full report (McKerrow, 1996) and consider conducting similar surveys in target communities. Overall results are shown in the table below.

Informal Support Provided to Zambian Families Caring for Orphaned Children, 1996

Type of Assistance	Proportion of Households Provided Support	Proportion of Households Willing to Provide Support
Advice	35.6	51.7
Labor	11.0	36.7
Material	18.7	35.6
Child care	16.4	43.9
Personal needs	16.3	27.9
None	2.1	8.0

Source: McKerrow, 1996

Sources of Support in the Private Sector and Special Purpose Communities

Information on special purpose communities (commercial farms, mining communities, large employers, the military) is not separated in the reporting of national survey data. However, other sources of data indicate that support systems are developing and can be stimulated in these settings (Mano, 1996). A recent NASTLP meeting with the Zambian National Federation of Employers found that employers are willing to provide resources both for AIDS prevention and impact mitigation programs but would welcome technical direction (Government of Zambia, NASTLP, 1996). Finally, Project Concern International (PCI) reports that the military has no formal support programs but has expressed interest in starting such programs.

Programs for Families and Children Affected by HIV/AIDS

There are probably more NGO, CBO and governmental assistance programs for families and children affected by HIV/AIDS than in any neighboring country. Their coverage seems to be low (see above) because most are highly localized, personalized and somewhat informal in their operations. In addition to community responses, the government and churches of Zambia have pioneered responses that anticipated the impact of the epidemic on their communities in ways that are duplicated by few countries in Sub-Saharan Africa. Zambia is truly a leader in this area.

The Government of Zambia has formally endorsed a home care strategy and encouraged district hospitals to work with health centers to establish formal hospital-to-home referral systems and to engage in case finding. Some of these have expanded their mission to include orphan monitoring and support for families caring for orphaned children. In 1986, the Church Medical Association of Zambia (CMAZ) adopted home-based care in its strategy to mitigate the impact of AIDS on affected families.

A 1994 study of home-based care in Zambia (Chela et al., 1994) reported that in 1992 there were 47 registered home-based care programs in the country. The study recommended that additional training be provided to health service providers and to families caring for terminally ill patients and community volunteers, and that community members be stimulated to start home care programs and establish linkages with health care facilities for support. It also suggested that the drug distribution system in the country be strengthened so that home caregivers could have increased access to medical supplies. Additional programs have probably been established since 1992 and existing programs expanded, but systematic data are not available.

In addition to formal home care programs, which employ medical personnel and tend to be comparatively expensive in their administration, many smaller, informal or voluntary organizations are providing services to their communities but are not registered by the government. Data collected by PCI during preliminary organizational meetings in three districts and with the military reveals a strong community-based response. Data collected by the consultants in Lusaka during their study supplement PCI findings for Lusaka, where PCI is now initiating coordinating activities.

AIDS Service Organizations in Three Districts of Zambia

District	Organizations in Planning Meetings	Number Providing Support to PLWHAs, Families and Orphans
Kitwe	8	4 Central Hospitals, 18 Health Centers, Society for Women and AIDS in Zambia (SWAAZ)
Ndola	20	4 Central Hospitals, 12 Health Centers, Ndola Catholic Diocese (4 areas), Child Adoption Society of Zambia (CASZ)
Livingstone	21	3 Central Hospitals, Health Centers Coordinated by Sepo, Catholic Diocese, World Vision
Lusaka	Not known	Not known Central Hospital, Health Centers SWAAZ in 4 areas, CINDI, SKI, YWCA, Tasinta, CASZ, Fatima Home Based Care, Kasisi and other orphanages, Catholic Diocese, other churches, Care; CHIN coordinates the work of 51 organizations in Lusaka and the Copperbelt
Monze	Not known	Not known
Chikankata	Not known	Central Hospital, Health Centers Not known Central Hospital, Health Centers, Chikankata
Nchelenge	Not known	No formal home care or orphan support programs identified by PCI

Sources: Chela et al., PCI, consultants' data collection

PCI will work with NGOs and DHMTs later this year to conduct formal inventories of AIDS service organizations in these three districts. This will enable them to identify the small, community-based, volunteer organizations that could not be identified for their initial planning meetings. Judging from the consultants' findings in Lusaka during a very brief data collection period, such organizations are likely to be proliferating in urban areas. Urban support systems may be based in the activities of District Health Management Teams, while rural areas for the most part probably continue to rely on smaller family and neighbor support networks and religious missions for their support.

Coordinating Mechanisms

There are several coordinating service organizations for nongovernmental AIDS service organizations and NGOs providing other types of programming. Some NGOs provide services in more than one district (Family Health Trust, CINDI) and serve as informal national coordinating mechanisms. In addition, the District Health Management Team is charged with coordinating local governmental and nongovernmental service activities, and there will be similarly constituted local committees to administer public welfare assistance.

NGO Coordinating Mechanisms in Zambia

Group	Membership	Level	Functions
Zambia National AIDS Network (ZNAN)	NGO/AIDS service organizations	National	Bring NGOs together for discussions, an annual meeting and networking
Children in Distress Network (CHIN)	NGOs assisting vulnerable children	National (Lusaka and Ndola)	Networking, joint services action research and tracking member services, advocacy
NGOCC	Women's development organizations	National	Member development, advocacy training, capacity building
NGO Consultative Forum	All NGOs	National	Donor oriented, coordination, capacity development
District Health Management Teams (DHMT)	Government (Health) NGOs, CBOs	National District Local	Coordinate all health services, stimulate development of new services
District Welfare Assistance Committees (DWAC)	Government (Community Development, Social Welfare NGOs, CBOs)	National District Local	Coordinating delivery of PWA social services and stimulating local, voluntary response
FHT/CINDI Lusaka, Ndola, Kitwe, Mufulira, Kalomo, Livingston, Chikene	Quasi-franchised national network funded by NORAD	District and Local Branches	Provision of material, social, education and income-generating programs for AIDS-affected families and children
Churches Medical Association of Zambia	All church-related medical services	National District Local	Provide and coordinate service delivery, service development, policy making, advocacy

Additional efforts should be focused on consolidating and improving membership services of the NGO groups so the competition for resources and potential duplication of services are not aggravated.

NGO-CBO, CBO-CBO and NGO/CBO-Governmental Links

As noted above, the resources and contacts of NGOs and CBOs are being accessed by government health workers through District Health Management Teams and Neighborhood Health Committees. Ndola District is best known for its rich linkages between government hospital and health center, church, and voluntary resources in providing home care and orphan care. District Welfare Committees are expected to work with local organizations to identify needy families in the community, distribute assistance to them, increase their access to health and educational services and monitor their well-being.

Government agencies also support the efforts of AIDS-related NGOs materially and strategically. The Ministry of Community Development and Social Services has funded NGOs for several years for community service development. The YWCA program for widow protection includes development of a special police unit in Lusaka that protects widows from property grabbing, while Street Kids International is sensitizing police to the needs of children living on the street. Chikankata Hospital and CMAZ have provided training in family assistance for AIDS-affected families to NGO/CBO and government personnel, while AIDS coordinators in Ndola and Kitwe have assisted NBO/CBO personnel in developing voluntary home care and orphan assistance systems.

Innovative linkages are also being established between NGOs and CBOs in Zambia. Mechanisms reported to the consultants include staff exchanges and linkages for technical exchange. One example is the Society for Women and AIDS in Africa/Zambia (SWAAZ), which coordinates with the YWCA in Lusaka to provide legal counseling to widows at SWAAZ centers in four compounds to reduce property grabbing. SWAAZ also links with Chikankata Hospital, which is known globally for its AIDS home care and counseling services, to provide staff training in community counseling, mobilization and development. CINDI, in Lusaka, Ndola and Livingstone, coordinates with other NGOs to develop AIDS-related services and assists its clients in accessing government resources in health care and education. CINDI links with World Vision in Livingston to provide food aid to destitute AIDS-affected families and children.

Geographic Coverage of Assistance

As noted above, although there are more organizations (government, NGO and CBO) in Zambia that provide assistance to families affected by AIDS than exist in neighboring countries, their coverage (as reported by families needing assistance) may be quite low despite the urban concentration of Zambia's population. Coverage may also be spotty and quality of care in need of improvement. Most organizations visited by the consultants reported a need for training, networking and capacity building.

It would be useful to have a mapping by district and within district of the reach and coverage of these services. In addition, the services of those community-based organizations providing care and support programs to families affected by AIDS that are not registered with the government have not been mapped.

Adequacy of Services

The Ministry of Community Development and Social Services has worked with NGOs to develop an NGO registration system. This system is now awaiting cabinet approval. The ministry is also developing a code of conduct to which NGOs must respond and expects to propose a law governing NGO activities by the end of the year.

Lack of access to medicine by families and ASOs hampers patient and family satisfaction and might be addressed through strategies to improve distribution of essential medicines in Zambia.

Integration of Income Generation with Health Interventions

Among Zambian health sector NGOs, CBOs and government programs interviewed by the team, there was consensus that the well-being of orphans and the quality of care they receive depends to a large extent on the capacity of the guardian household to maintain their livelihoods. As the HIV/AIDS disease progresses along the HIV Prevention to Care Continuum, the resources of households are quickly eroded as parents become caregivers for sick family members, become sick themselves or take in orphaned children. In urban areas, households that lose wage earners employed in the formal sector must rely on self-employment, usually in the informal sector.

This is consistent with the findings of a recent survey (Parker, 1996) that one out of four Zambian households engages in some form of income-earning activity within the informal micro and small-scale enterprise (MSE) sector. In rural areas, the same scenario also means that there is less (or no) labor available to continue farming. Families that are already relying on self-employment in the informal sector or on subsistence farming struggle to make ends meet and are pushed further into poverty. During such times of severe economic stress, food security, adequate clothing, access to school and health services for the family, particularly the orphans, is seriously threatened. The Zambian MSE sector appears to serve “a critical role in absorbing poorly skilled individuals and in providing steady but low returns to owners, workers and their families” (Parker, 1996).

Such a vital component warrants the same rigorous analysis as that given to health interventions. Many organizations working in the health sector recognize the important role that earning an income plays in the communities where they work. However, income generation is not generally thought of in terms of micro enterprise development and appears to be viewed as

something of a panacea in mitigating the weakening economic situation of families and children affected by HIV/AIDS. Because panaceas are commonly the result of wishful thinking, they are not critically analyzed. Moreover, health sector professionals do not necessarily have the background to do so effectively. Consequently, the term income generation project is used indiscriminately to describe activities that are, in reality, quite different from one another in their technical assistance needs and project design approach. For example, CBOs start income-generating projects in an effort to create a sustainable source of funds for the relief they provide to families under extreme pressure. These same CBOs will sometimes give a small amount of their available funds directly to a needy family to finance an income-generating project that the family can carry out. Health sector NGOs and GOZ initiatives promote group and individual income-generating projects as a way to assist widows, adolescents about to be orphaned, commercial sex workers that want to retire or families that are responsible for orphans. These projects can range from those that require significant capital investment and high-quality production and management skills (sewing) to those that need only working capital, no production and minimal management skills (petty trading, scone making).

Although an exhaustive survey was not possible, it appears that most income-generating projects promoted to respond to the impact of HIV/AIDS are used to provide resources to CBOs. According to CINDI staff, engaging in income-generating projects is a typical communal response to raising funds for community needs. However, these traditional activities are normally intermittent, one-time efforts that are organized so as not to interfere with individual livelihoods.

The kind of pressure experienced by households affected by AIDS overwhelms these modest fund raising efforts and prevents the CBO from being able to scale up. CBOs, and the NGOs that support them, therefore tend to turn to more formal projects that are better defined as micro or small businesses. However, the most popular types of businesses often require significant capital investment and advanced production and management capabilities (hammermills, for example). They are often recommended to people who lack the necessary experience. On-going group businesses are notoriously risky endeavors that typically have enormous difficulty in generating significant profit. In addition, the time and effort necessary to make a group business successful may eventually overtake the original purpose of a CBO.

Examples of Income-Generating Activities

Level	Primary Purpose of Income
Individual (healthy household member, widow, PLWA, adolescent orphans, previous CSW)	Training, advice, cash or credit provided directly to individuals so they can engage in business or income-earning activities and thus adequately cope with the impact of HIV/AIDS and provide for the children and orphans in their care. In some cases the businesses are group- or communally managed. Returns from the activity are meant to be used directly by the individuals of the group.
Community based organization (church, widows, youth)	Communally supervised or managed ongoing businesses or intermittent income-earning activities as a way to achieve organizational sustainability. Returns are used to finance the groups' interventions or community development activities. At times proceeds from activities are used as incentives for volunteers, but the ultimate purpose is to maintain them as productive members of the organization.

Designing Effective Income-Earning Assistance Programs for HIV/AIDS Impact Mitigation

Organizations working to develop micro enterprises that are experienced in strengthening the economic resources of the poorest households have learned that it is essential to make clear distinctions about the intended client, her/his purpose for earning income, and the appropriate level of economic activity. It is only then that one can determine the best match of corresponding assistance and design a sustainable project that achieves the desired results. To do this also requires that project planners and implementors have business acumen and field experience at the grass roots. Staff must be able to translate academic and sophisticated business management concepts into relevant techniques that can be used by the entrepreneur to improve the humblest of economic activities.

The definitions in the table below are actually more descriptive of the owner's socioeconomic status than of the business itself. Consequently, the categories are not static, and an owner's business may change over time as a result of any number of events. It is entirely possible that an owner living in a household affected by HIV/AIDS could slide very quickly from the micro enterprise category to survival to destitution.

Category	Characteristics
Survival-level income-generating activities	An intermittent or vulnerable activity. In rural areas, a seasonal activity to supplement subsistence farming that requires inexpensive or no fixed assets and modest or no production skills. The owner views the activity as a survival technique and does not identify it as a business. Income earned is urgently needed for household survival because the owner is among the poorest but not destitute. Working capital is in constant danger of being eroded in the face of very real crises.
Micro enterprise	A sustained and more stable activity. Some inexpensive fixed assets are more likely. Sales volume is small but steady so that working capital is cushioned in the event of unexpected needs. Reinvestment is possible, but growth is difficult. The owner may have one or two employees. The owner's household is poor but not among the poorest.
Small enterprise	Significant (relatively) fixed assets are most likely. A strong sales volume is necessary to be profitable. The activity probably requires quality production and management skills. The owner is growth oriented, and profits are adequate for business growth and for supporting family needs. The enterprise may employ several people.

Note: USAID defines micro enterprises simply as employing less than 10 people. However, in many African countries, 10 employees would be considered a substantial business. Many micro enterprise NGO practitioners define characteristics of businesses for the purpose of project design and differentiate between micro and survival levels.

Appropriate Focus and Types of Assistance

The most effective interventions are those that target support to income-earning activities for which people already have most of the necessary skills and ongoing access to markets and resources. Externally introduced business initiatives with which participants have little experience typically incur significant costs and have generally poor track records.

Assistance should also be directed toward support to individuals in poor households before they experience the impact of HIV/AIDS. Doing so may lessen the erosion of resources and slow a decline from poor to poorest and hopefully prevent a final slide into destitution. Hence, the aim of targeting assistance to the survival economy is not employment creation or business growth but rather poverty mitigation.¹ Moreover, households whose economic resources are at least stable are in a position to provide relief to a neighbor, friend or family member; become active in a CBO; or absorb children orphaned by HIV/AIDS.

¹ B. McNelly and C. Dnford, "Are Credit and Savings Effective Against Hunger and Malnutrition?" Freedom from Hunger, February 1996. This literature defines credit that targets those in the survival economy as "poverty lending." Lassen, as cited in the same report, indicates that, "With poverty lending it is legitimate to support sizes and types of activities (petty trading) and uses of surplus (to feed one's family) that are not promoted with producers and firms at higher levels on the economic ladder." In addition, Lassen points out that although the target groups may differ, poverty lending and microenterprise credit follow the same financial principles and methods

Micro Finance

Micro finance loans are deliberately kept small to attract the poorest households, which typically engage in short-term, rapid-turnover trading activities. These are the very activities most likely to benefit significantly from infusions of additional working capital provided through a loan. There is evidence that micro finance has a positive impact on poor families' ability to afford the very basic of necessities and improves household food security.² If implemented and managed according to state-of-the-art principles, micro finance can recover costs and be a sustainable intervention without creating a welfare mentality. In addition, when individual accountability for the loans is achieved through group liability and peer pressure, there are indications that a group itself can become a safety net for its members. In fact, in one of the PULSE credit groups, when a member became ill, her peers decided to take turns running her business so she did not default on her loan. When she died, they proposed that someone in her family join their group and take over her business. Even though this action was motivated by the group's liability for its loans, it does indicate the beginning of social cohesion and community-based solutions to very difficult situations.

As stated earlier in this report, development of micro enterprises is key to any HIV/AIDS impact mitigation efforts. Zambia has a nascent micro finance movement, although its outreach is limited. Partnership with these organizations could provide the health sector with an essential tool in strengthening households' ability to cope economically.

Savings Mobilization and ROSCAs

Making credit available to poor households works best in areas where there is a concentration of year-round business activity. This poses an obvious problem for rural and remote areas that are not within easy access to market centers. Rural households dependent on seasonal agricultural ordinarily rely on in-kind savings to provide them with revenue throughout the year. In-kind savings usually take the form of livestock or storing maize for later resale. Many households also save cash within the home, and anecdotal evidence suggests that many families have large cash stores at home.³ For such areas, savings schemes or savings-led credit initiatives are more important than credit alone. However, creating revolving savings and loan schemes is challenging. Although there are cases of successful revolving credit funds in Zambia (a widows group in Ndola), their loan fund is based on funds mobilized in the community. The minute externally supplied funds are injected into such efforts or, worse, used to start one, the capital is in

² B. McNelly and C. Dnford, "Are Credit and Savings Effective Against Hunger and Malnutrition?" Freedom from Hunger, February 1996. See also International Food Policy Research Institute, "Rural Financial Markets and Household Food Security: Impacts of Access to Credit on the Socio-Economic Situation of Rural Households in Malawi," September, 1996.

³ Adam Folkardof, Richard Woodroffe & Associates, "Savings Mobilization-Options for the EEOA Project," January, 1997. This report contains many excellent recommendations on various methods to stimulate savings mobilization informally.

danger. People begin to remember the precedent set by externally funded government programs in which credit repayment was not enforced. The need to capitalize on social and peer pressure to hold people accountable for externally supplied loan funds is a cardinal rule of successful credit projects.

Linking to Growing Markets

The MSE national survey (Parker, 1996) pointed out that connecting business owners to more thriving markets could improve the income of households that rely on self-employment in the sector. CLUSA and SIDA's Economic Expansion to Outlying Areas are examples of projects that link rural farmers to outgrowers groups that market agricultural produce. ZMAP is a project that is beginning to link smaller businesses to larger firms for advice and mentoring. The larger firms could also be a new market for the smaller firms' goods or services.

Where a household has reached destitution and cannot manage to provide any food for its members, relief from a CBO or public assistance scheme is the more appropriate response, at least for a short period of time.

Government Responses

Ministry of Community Development

Government programs to assist needy families and children are officially the province of the Ministry of Community Development, Social Services, and Culture, which is divided into three departments (Social Welfare, Community Development and Culture). The Social Welfare Department is responsible for child fostering and adoption, which it administers through subvention to the Zambian Adoption Society. Currently, families that foster children receive small subsidies. While few families do, fostering and adoption are increasing in popularity with the growth of AIDS-related mortality.

Social Welfare also registers and supervises children's homes (orphanages) in Zambia. The department is aware that many children's homes are being developed in response to the AIDS epidemic, most of which are informal and do not apply for registration. Public Welfare Assistance (PWA) is also administered through Social Welfare. Although PWA has existed for many years, it has been under funded so most families and organizations interviewed stated that they do not attempt to use it. The government is planning a major expansion of the scheme, which will be community administered. The community committees will be trained to review need following specific criteria for assistance, including chronic illness and orphaning. Community committees will also be trained to identify and monitor vulnerable families that are beneficiaries of the scheme. Full-scale implementation is expected to begin in 1998.

The community organizations and individuals the consultants interviewed said that they did not believe that public assistance was an acceptable solution. They preferred development of income-generating activities and employment for AIDS-affected families, widows and children they are more sustainable and productive interventions.

The Community Development Department has provided income-generating programs as part of its development services. These are administered by the District Development Committees and will be coordinated with public assistance through the District Welfare Assistance Committees. Currently, with funding by the EU, the ministry is developing an enhanced program through Microbankers Trust, which will be implemented over the next five years.

Ministry of Health

As noted above, the NASTLP established home health care programs and policies in the 1980s and is responsible for registration of home health care providers. Many of these programs also provide assistance for families with orphaned children following the death of the chronically ill patient. Such assistance is provided primarily through volunteers and church-related mechanisms. In addition, families receive assistance in accessing government entitlements. Although the ministry has in place a policy to guide providers of orphan care, it has met with little success. A working group whose mandate is to develop policies for vulnerable children, including orphans, also has accomplished little. However, the ministry appears to be surfacing concern for orphans on the policy agenda with more force. As noted above, the lead ministry in this area is Community Development.

The government has fostered the growth of church-and NGO-sponsored services for families affected by HIV/AIDS through technical assistance and by encouraging donor support in its national AIDS plan. In addition, the Central Board of Health also has responsibility for all institutional care provided to AIDS patients. NASTLP is working with the World Food Programme to provide food support to chronically ill patients, children who are food insecure due to the death of an adult, and patients with tuberculosis in institutional or home-based programs. The program will be administered through district home health care teams.

Ministry of Education

To reduce the cost of schooling for parents, the Ministry of Education has removed the requirement for uniforms, an action that seems to have mixed support. Free universal primary education is not contemplated by government officials, although it has been implemented in several neighboring countries as a response to the AIDS epidemic (Uganda) and to poverty (Malawi). In Zambia, the community school movement, spearheaded by UNICEF, seems to be

filling the gap, providing low-cost alternatives to free education through focused and limited

training in essential literacy, numeracy and skills development. The community school movement also seeks to expand school capacity, particularly for primary education. It appears to be an urban mechanism.

Many NGOs and CBOs that provide assistance to families affected by HIV/AIDS and also those that provide assistance in community development have added or plan to add community schools so orphaned children in their service populations will receive essential schooling. SWAAZ, an AIDS service organization, has added primary school services as a way to educate orphans and earn additional income through the enrollment of fee-paying students.

V. RECOMMENDATIONS

The situation of families and children affected by HIV/AIDS is at a delicate turning point. HIV/AIDS-affected families, many of whom were already among Zambia's poor, are slipping toward destitution as a result of high medical expenses, loss of income from the wage earner's illness and subsequent death, and the costs of caring for children orphaned by the death of family members. A large proportion of orphaned children are in the care of grandparents, and that proportion is increasing as more children lose both parents to the epidemic. The situation of guardians is often quite precarious. Not only have many lost the ability to earn an income because of their age, they also have the additional burden of caring for chronically ill adult children and their grandchildren.

Although Zambia is a world leader in developing public and private resources to assist families and children affected by HIV/AIDS, the geographic coverage of these services is relatively limited. Few families have made use of such services, and satisfaction is low due to the severe resource constraints that such programs face.

Families prefer to provide care for chronically ill patients at home, and communities prefer to retain HIV/AIDS-affected parents and children in the community and preferably in their own homes. The majority of community members also express a willingness to share their resources and provide assistance to the extent of their capabilities, and few approve of public assistance as a long-term strategy. The formal private sector has expressed a willingness to support HIV/AIDS prevention and mitigation services, and many organizations are forging links with the government and NGOs to further their ability to do so.

Recommendation 1: Program Additional DCOF Funds in Zambia

These conditions are extremely conducive to successful programming of additional monies from USAID's Displaced Children and Orphans Fund in an integrated program for families and children affected by HIV/AIDS following the guidelines established in the DCOF-Global HIV/AIDS Division's recently commissioned study, *Developing Strategies and Policies for Support of HIV/AIDS Infected and Affected Children* (Hunter and Williamson, 1997). This study details community-based responses to the epidemic and advocates their development as the only affordable, acceptable and sustainable approaches to mitigating the epidemic's impact in countries around the world.

DCOF funds could be successfully absorbed in Fiscal Year 97 by the USAID Mission in Zambia, although the Mission needs to develop an action plan that is compatible with the existing management capacity.

Recommendation 2: Strategy Development

The consultants have reviewed four aspects of strategic intervention with USAID/Zambia

Mission staff:

1. **Urgency.** As noted above, the condition of many Zambian families caring for chronically ill patients and their children is worsening. There are already 1.7 million orphans in Zambia, one of the highest orphan burdens in the world. A delay of one or two years in the availability of funds and development of implementation mechanisms will mean the loss of caring capacity for thousands of Zambian families and perhaps the loss of a will to provide community-based care for many thousands more. The consultants were not able to estimate the opportunity costs of such delays as part of this consultancy, so only the grossest of estimates can be made.

Estimating the nature and cost of impacts on the Mission's health Strategic Objective (SO) and other SOs was also not part of the scope of work of this consultancy. It is nonetheless clear from already measured impacts on the mortality of infants and children in other Sub-Saharan African countries that HIV/AIDS is taking its toll on the effectiveness of child survival programming by USAID and other donors. UNICEF stated in 1990 that all of the gains realized by child survival initiatives over the past few decades will be wiped out by the epidemic. Programs currently in place must make every effort to dampen this impact, and protecting the health of the epidemic's most vulnerable victims--AIDS orphans--will play a critical role in this effort.

The consultants recommend that USAID/Zambia make concerted efforts to expand awareness in Zambia, including presenting and discussing this report, and the new estimates of orphans by the U.S. Census Bureau that it contains, in public forums. In addition, the Mission can support speedy development of an explicit government policy for orphaned children. Such a policy would advocate support and development of community-based care, promote expanded rural and urban coverage, institute mechanisms for the protection of widows, establish or clarify the responsibility of the private sector in providing prevention and mitigation programs, and describe the preferred and feasible role of orphanages in providing care. Concerned ministries include Health, Community Development and Social Services, Youth and Sport, and Education. The policy should be widely circulated to government agencies, the private sector, NGOs and CBOs.

In addition, if time allows, USAID/Zambia could expand the awareness of other Missions about programming strategy and feasibility.

2. **Realism.** As noted above, the scale of the problem dictates community-based responses. Such responses must take into account Zambia's current socioeconomic situation and the widespread poverty of the people. Donor assistance should increase support to households and communities through capacity building with CBOs. In addition, the scale of the problem dictates that private sector resources be harnessed, which will also increase the long-term sustainability of any interventions. HIV/AIDS orphans in Zambia will number in the millions for at least 15 years, so the sustainability of community-based interventions is critical. In addition to

linkages with the formal private sector, community-based interventions need to develop more sophisticated linkages with microenterprise and microcredit resources so that economic opportunities for HIV/AIDS-affected families will expand.

A realistic appraisal of the problem and strategies to address it is critical. More data are needed to estimate the number of HIV+ children and the capacity of institutional services, for example. In addition, data for monitoring programs and for understanding the intersection of health and private sector programs would be useful to improve programming.

3. Need for Programs that Are to Scale or that Go to Scale Immediately. HIV/AIDS seroprevalence data demonstrate that programs must be effectively expanded to rural as well as urban communities. Fortunately, there are private sector groups available to do this, including the Church Medical Association of Zambia (CMAZ), which provides the bulk of rural programming, and the Zambia National Farmers' Union, which has successfully pioneered prevention programs in one district. In addition, the Zambia Federation of Employers, in a workshop with the NASTLP, has indicated its willingness to support urban and rural programs. Commercial organizations are willing but need templates for action and links with experienced public sector organizations.

Public sector resources for taking a program up to scale quickly are available through the health sector, which has demonstrated its effectiveness in HIV/AIDS prevention and care programs through District Health Management Teams. The Ministry of Community Development and Social Services will educate local committees to identify vulnerable families and will provide a safety net through its Public Welfare Assistance Scheme while other resources are being developed. In addition, the ministry will be implementing a major microcredit initiative that could be linked with the impact mitigation efforts of AIDS service organizations.

Umbrella organizations, private sector and NGO, are another significant resource in the health, economic and community development arenas. The education sector has provided a national delivery system for HIV/AIDS prevention efforts and could be harnessed to provide messages about family care, orphaning and women's and children's rights. The media is an excellent mechanism for changing public attitudes and practices concerning widows' and children's rights and for training family caregivers in the basics of health and psychological assistance. The proposed food support programs will also provide an additional national mechanism for the delivery of assistance.

4. Roles and Responsibilities. Development of a national orphan policy will help to clarify the most cost-effective roles for all actors in such a program. To build the capacity of community organizations to provide care, effective partnerships must be built, including those that join international and national NGOs and local CBOs through partnerships, subcontracts, capacity

building and coordination mechanisms; health sector and economic sector resources, that link government and nongovernmental resources such as the DHMT; and public-private sector agents through partnerships and contracts with NGOs and CBOs.

Recommendation 3: Tools for Realizing the Mission Strategy

The consultants have reviewed the following tools for realizing USAID/Zambia strategy with Mission staff:

1. Awareness Raising. The Health Sector Team can inform Mission staff in other sectors of the severity of problem and strategies to address it. For its part, the Mission can promote dissemination of information to and discussion with other donors.

2. Integrated Programming for AIDS-Affected Families with SO3.

- Short-term efforts include:
Raise the awareness of current Cooperating Agencies (CA)
Ensure coverage for children through current health programs
- Long-term efforts include:
Links with ZHIP (see chart)
Development of RFA
Description of scope of problem
Criteria for CAs bidding ZHIP
 - Community-based programming skills
 - Demonstrated concern and experience with program development for children and families affected by AIDS
 - CA groups to include at least one experienced economic development CA
 - Explicit data collection, monitoring and evaluation plans
 - Overlap of target populations (health and economic)
 - Household coping strategies
 - Orphan/nonorphan treatment
 - Media capacity for moving programs to scale
 - Sufficient policy development capability
 - Ability to provide CBO/NGO capacity buildingCoordinate Proposal Review with Other Sectors

3. Link with Other Mission SOs. The Mission's SO3 team can continue its exploration of synergistic intersections with (a) the Mission's Strategic Objective in economic growth because of the importance of microfinance and linkage to markets of CBO income-

generating projects and (b) with the Mission's agricultural assistance SO for market linkages and savings mobilization.

4. Health Sector Program Assistance (SPA). The Mission is currently reviewing possibilities for nonproject assistance with the Ministry of Health and has specified the need for assistance to families affected by HIV/AIDS as an area of discussion. A possible Conditions Precedent for SPA might be the development of an explicit national policy on orphans, or the advancement of Public Welfare Assistance targeting widows and orphans.

Recommendation 4: Alternative Implementation Mechanisms

For FY97

To expedite the obligation of DCOF funds, the consultants recommend that programming be initiated through existing CAs for Fiscal Year 97. Project Concern International (PCI) currently implements the Mission's HIV/AIDS project and appears to be accepted and respected by government, private sector and NGO actors critical to the success of an expanded program. Additional DCOF funds could be programmed through an amendment.

PCI's program should include the following elements:

- Programs developed with ZNFU and ZNFE
- Policy development
- Collaborative development of NGO-CBO roles and responsibilities, policies and operational strategies
- Promotion of networking
- A strategy for capacity building
- Links with NGOs/CBOs/private sector agencies focusing on community economic growth
- An expanded small grants program for innovative CBOs
- Expanded media development for issues development and awareness raising, widows' education and caregiving

For FY1998-2002

Programming for families affected by HIV/AIDS can be effected through the Mission's ZHIP bidding process (see above).

Recommendation 5: Data Sufficiency

Data on the orphaning situation in Zambia are rich. National surveys provide information on orphaned children and their families that is unmatched in neighboring countries. No extraordinary data collection needs are needed for the Mission to develop FY97 or FY98-2002 programming. In fact, the Living Conditions Survey might provide sufficient baseline data for the evaluation of Mission initiatives for families affected by HIV/AIDS. In the future, as part of its policy efforts, the Mission should encourage the inclusion of data on orphans in the next census and exploit DHS's capabilities in this area to add to the store of existing data.

Special data collection needs are being addressed by UNICEF, including generation of data on:

- Urban/rural placement of children following parental death
- Economic activities of urban and rural families affected by HIV/AIDS
- Impact of existing microcredit and business development projects on the ability of families and communities to cope with HIV/AIDS, including the proportion of families assisted who are HIV/AIDS-affected

More information is needed about household coping strategies in order to design sound project interventions that best support existing techniques. Anecdotal evidence uncovered during the team's interviews with microenterprise development projects (microfinance and outgrower group development) revealed that many clients are members of families that are affected by HIV/AIDS and are caring for orphans and who seem to be coping.

Microenterprise staff are not considering whether their clients are caring for orphans or living with HIV/AIDS. Consequently, these households escape the net of data collection in the health sector. For example, the primary clients of PULSE are women who are the sole income earners in their households or whose husbands make only a modest contribution. PULSE's baseline survey (1996) reported that the percentage of widows among their clients in George and M'tendere compounds is 5 percent and 20 percent, respectively. An informal survey by the team in George revealed that eight of 20 members in one group were caring for a sick family member or orphans. One woman said she was getting a loan because her brother had just died and she knew she would be taking in his seven orphaned children. A longitudinal study of clients of microfinance projects (in collaboration with the project staff) could lend new insight to strategies that support coping mechanisms.

Recommendation 6: Monitoring and Evaluation

Participatory data collection and analysis with CBOs is encouraged for evaluation and monitoring purposes. In addition, data are needed on orphanages (number, type), and good estimates of HIV+ infants would be welcome.

Recommendation 7: Private Sector Linkages

If the Mission incorporates private sector linkages through formal sector businesses, it may want to explore willingness to:

- Develop and advocate workplace benefits policy
- Encourage government to create incentives for participation in various HIV/AIDS impact mitigation efforts
- Engage private sector firms in ways that meet their interest, for example, proposing that sponsoring an event will purchase them public goodwill and provide an opportunity for advertisement
- Organize or leverage corporate funds (Zambian Federation of Employers and large private sector firms) to finance CBO activities directly or NGO interventions that would strengthen the organizational capacity of the CBO. In the rural areas, the commercial farming sector is an enormous untapped resource for such financing.
- Create a multicorporation foundation for HIV/AIDS orphans

1.Strategic Linkages. Enabling a family to begin, maintain and grow its income-earning potential is key to helping the family cope with HIV/AIDS. Support to, and understanding of, the MSE sector should be a critical element in the development of any package of interventions seeking to mitigate the socioeconomic impact of HIV/AIDS. However, it is not recommended that health projects take on the challenge of crafting microenterprise interventions, particularly not microfinance. A better approach is to join forces with the microenterprise development sector so that projects are linked not only vertically within the health sector but also horizontally across other technical sectors. This would allow the health sector to sharpen its focus while still capitalizing on the contribution that income earning can make to strengthening family economic resources. In this way, synergies also will be created.

2. Overlaying Strategic Objectives. Again, it is important to take advantage of potential synergy. This will not happen if each sector develops its strategic intervention package in isolation from or without knowledge of the issues the other sector faces. Results could be enhanced by ensuring that any microfinance institutions supported by the Mission coincide with the geographic coverage of ZHIP and vice versa. Any strategy devised by the private sector office for microfinance development will automatically emphasize scaling up outreach (increase in geographic coverage), but the health sector should also lobby for scaling deep into the survival economy (reaching poorest of the poor), where the most urgent pressure is being felt by families and children affected by HIV/AIDS.

3. In Search of Sustainability. CBOs and organizations working with them are right to be concerned about their sustainability. More efficient methods than ongoing small businesses

for creating sustainable sources of funds for a CBO's budget must be identified. Linking CBOs to private sector sources of funds may be a possible route. More creative fund-raising activities must be also identified to supplement the usual bake sales and dinner dances and the sale of communal agricultural production. The following table details these types of activities.

Economic Intervention	Criteria
Support income-earning potential of households and individuals	<ul style="list-style-type: none"> - Emphasis on existing businesses or income generating activity. - HIV/AIDS project implemented in partnership with an organization with a good track record in microfinance project design and delivery. Microfinance must be based on cost recovery principles and client accountability for externally provided loan capital. Emphasis should be on achieving scale, both geographically and the depth or reach into the survival economy. -Any additional support (besides credit) should include linkages or information about viable markets or economical sources of raw materials. - Community revolving loan funds capitalized with community savings and matching funds.
Support financial capacity of CBOs	<ul style="list-style-type: none"> -Alternative methods for raising funds. -Tap into private sector sources of funds. -Provide technical assistance to strengthen the organizational capacity of the CBO.

APPENDIX 1

PERSONS INTERVIEWED

Name, Title and Organization	Date	Duration	Topics
Pious Chibinga, Evaluation Officer Economic Expansion in Outlying Areas Project, Richard Woodroffe & Associates (Formerly Ministry of Agriculture HIV/AIDS point person)	June 5, 1997	1 hour	Project purpose and organization, sponsorship, project rapid assessment, impact of shift from command to market economy on rural economy, approach to needs assessment and identification of small loan beneficiaries, rural HIV/AIDS prevalence and coping strategies
Greg Duly, Country Director, CARE Zambia	June 5, 1997	1.5 hours	CARE project portfolio, budget and catchment area, health and microbusiness projects, HIV/AIDS activities in Lusaka compounds, Foster Parent Association activities, situation of urban families coping with HIV/AIDS, urban poverty, urban community organization
Masauosa Nzima, Associate Project Director, Project Concern International (PCI)	June 5, 1997	2 hours	PCI project organization and staffing, program elements and strategies, bridging program objectives, district operations and progress, project timetable
Paul Zeitz, M.D. , Senior Policy and Technical Advisor, USAID	June 6, 1997 June 11, 1997 Debriefing	1.5 hours .5 hours 1.5 hours	Scope of work, ZHIP strategy and integration of USAID health interventions, USAID HIV/AIDS program, USAID CAs, development of ZHIP RFA, decentralization and integration of GMZ Ministry of Health, MOH technical guidelines for frontline health workers, Essential Health Package, relationship of orphan interventions to community based AIDS program, family planning and child survival programs, role of orphanages, food aid (NACP and PCI), DCOF levels of funding and implementation mechanisms
Bernadette Oloor-Freers, M.D., UNAIDS Representative	June 6, 1997	1 hour	UNAIDS strategy, program components, and funding, relationship to GMZ MOH and NACP strategy, UNICEF and UNDP strategies ESIP and educational reform, Social Welfare changes, urban-rural migration, role of orphanages
Deborah Bikel, Country Director, Project Concern International	June 6, 1997 June 9, 1997	2 hours 2 hours	Organization and strategy of PCI's HIV/AIDS program, progress in districts, current community based activities; involvement of private sector in project strategy and development, plans for evaluation, indicators, economic activities
Robie Siamwiza, Policy Advisor, Project Concern International	June 6, 1997 June 9, 1997	2 hours .5 hours	PCI/NACP policy development, social welfare and public assistance, fostering and adoption policy, education reform, role of orphanages

Name, Title and Organization	Date	Duration	Topics
Mike Sinyinza, A.J. Mlewa and Sitwala Mungunda, Project Officers, PCI	June 6, 1997 June 9, 1997	1.5 hours .5 hours	PCI's objectives in community based programming, district development strategies and process, organization and reception at district level, HIV/AIDS programmatic areas, existing resources for community care in 6 districts and military, involvement of private sector, approaches to evaluation, development of indicators
Ron Philips, Project Director, Cooperative League USA (CLUSA)	June 9, 1997	1 hour	Overview of CLUSA's support to agricultural production in rural and periurban areas, support to families and children affected by AIDS, impact of AIDS on their work, existence of community based support to HIV affected families
Paul Hartenberger, PHN Officer, USAID	June 13, 1997 Debriefing	1.5 hours	Scope of work, ZHIP strategy and integration of USAID health interventions, USAID HIV/AIDS program, USAID CAs, development of ZHIP RFA, situation of AIDS and orphans in Zambia, relationship of orphan interventions to community based AIDS program, family planning and child survival programs, role of orphanages, food aid (NACP and PCI), DCOF levels of funding and implementation mechanisms
Mark White, HIV/AIDS Program Officer, USAID	June 9, 1997 June 11, 1997 June 13, 1997 Debriefing	1.5 hours .5 hours 1.5 hours	Scope of work, ZHIP strategy and integration of USAID health interventions, USAID HIV/AIDS program, USAID CAs, development of ZHIP RFA, relationship of orphan interventions to community based AIDS program, family planning and child survival programs, role of orphanages, food aid (NACP and PCI), DCOF levels of funding and implementation mechanisms
Mrs. Matondo Monde Yeta, General Manager, Women's Finance Trust	June 9, 1997	1 hour	Overview of microcredit project, proportion of households affected by HIV/AIDS, profile of client base, observations on positive impact of microcredit program on client's ability to cope, review of type of information collected for impact evaluations
Louis Mwewa, Liaison Officer, Children in Need Network (CHIN) Secretariat	June 9, 1997	1 hour	Origin, mission, and objectives of CBO-NGO coordination mechanisms, membership, geographic coverage, 1997 work plan, support needs for community care organizations, community school organization

HIV/AIDS Orphans and NGOs in Zambia

Professor Nkanda-Luo, Deputy Minister, Ministry of Health	June 9, 1997 June 10, 1997 June 11, 1997	3 hours 2 hours 2 hours	Policy development for families and children affected by AIDS, NGO activity and coordination, donor funding mechanisms (maximizing expenditures for CBO activity), NASTLP reorganization and development of the National AIDS Council, coordination with Ministry of Community Development and Social Services, site visits to SWAAZ and TACINTA
Kibibi Mtoro Nassoro, UNV & Eric Ngoma, Accountant, TASINTHA Programme	June 9, 1997	1.5 hours	Site visit to review business, production and leadership programme, potential revolving credit initiative, program organization

Name, Title and Organization	Date	Duration	Topics
Guy Scott, Mano Consulting and Zambia National Farmers Union	June 9, 1997 June 11, 1997	1.5 hours 3 hours	Prevention and impact mitigation on commercial farms in Makambuko, prospect for expansion of program in 10 districts, development of co-funding by commercial farming interests (Lonrho, Zambezi Ranching, Zambia Sugar), coordination with PCI
Doug Webb, Ph.D., Research Officer, UNICEF	June 10, 1997	2 hours	Research on families and children affected by AIDS, programming by UNICEF and other organizations
John Musanje, Project Officer, CINDI	June 10, 1997	2 hours	Development of CINDI, growth of project activities, community involvement, extent of HIV/AIDS problem in compounds served, sources of support, future project plans and funding, data collection efforts
Chitalu Mumba, CINDI Social Worker, and members of three families affected by AIDS (CINDI site visit)	June 10, 1997	4 hours	Interviewed three families affected by AIDS. They included grandmother with 3 children, middle income; 2 young women, ages 18 and 20, heading a household of 4 children; 2 grandparents with 16 orphaned children ages 1 year to 20 years. Discussed death of relatives and how guardians came to care for children, material and psychological problems faced, assistance received from government, family, community, and CBOs, access to schooling and health care, income generation activities, housing, food, plans for future
Moses Sichone, M.D., Director, National AIDS, STD and Leprosy Control Program	June 11, 1997 June 12, 1997	.25 hours 1 hour	Current and project HIV seroprevalence, estimated number of AIDS orphans, program plans for coordination and policy interventions, data collection plans
Mr. Magola, Deputy Permanent Secretary, Ministry of Community Development and Social Services	June 11, 1997	1.5 hours	Current and future Ministry programming for families and children affected by HIV/AIDS, revisions in policy and social programming, development of social welfare role, adoption and fosterage, protection of property, development and funding of Public Welfare Assistance scheme, NGO coordination and licensing, Community Development Department activities in income generation
Doris Mutunwa, Principal Planner, HIV/AIDS Focal Point Person, Ministry of Community Development and Social Services	June 11, 1997 June 12, 1997	1.5 hours 1 hour	Current and future Ministry programming for families and children affected by HIV/AIDS, revisions in policy and social programming, development of social welfare role, adoption and fosterage, protection of property, development and funding of Public Welfare Assistance scheme, NGO coordination and licensing, Community Development Department activities in income generation, activities of Ministry Focal Point

Name, Title and Organization	Date	Duration	Topics
2 representatives, Catholic Women's Organization (CWO)	June 11, 1997	.25 hours	Number of parishes in which Catholic Women's Organizations are operating, charitable activities and how they are organized, number of women volunteers in CWOs in 18 parishes in Lusaka, material and spiritual need of families affected by AIDS, protection of widows' property, coordination with Legal Aid Society, YWCA, fundraising and income generating activities
4 members, Society for Women and AIDS in Zambia (SWAAZ), Bauleni	June 11, 1997	2 hours	Site visit to review community homes for AIDS orphans and other community support mechanisms; history of SWAAZ activities in Bauleni, preschool and primary school activities, income generating activities in baking and carpentry, their own experiences with HIV/AIDS, treatment of children and widows, protection of widows property, community education, links with YWCA Legal Aid Society, links with Chikankata for community counseling training, sponsorship of orphans for training to work with SWAAZ branches, living conditions of children, access to education
Clare Blenkinsopp, Project Officer for Families and Children Affected by AIDS, UNICEF	June 11, 1997	1 hour	Overview of UNICEF's programs for families and children affected by AIDS, CBO and NGO activities and relationships, CHIN, community schools,
Karen Romano, PCI	June 12, 1997	1 hour	Community based care, economic interventions in PCI districts and examples of income generation efforts of other health sector NGO's
Dr. Nkanda Luo, Pediatrics Department, University Teaching Hospital	June 12, 1997	1.5 hours	HIV+ infants and children, home based care program
Michael Mbulo, Assistant Project Director, Microcredit Initiative, CARE	June 11, 1997	3.5 hours	Site visit to George compound, interview with client groups to discuss type of business and impact on livelihoods. Also conducted informal survey of number of clients caring for sick family members or relatives and orphans. Meeting in office-overview of microcredit project, proportion of households affected by HIV/AIDS, observations on positive impact of microcredit program on ability to cope, review of information collected for base-line survey ,

Name, Title and Organization	Date	Duration	Topics
Priscilla Mwiindilila, Information Officer & Bertha, Southern District Coordinator, Women for Change	June 12, 1997	1 hour	Overview of project and objectives, project methodology, approach to promoting economic activities, impact of HIV/AIDS among client group, and how it is articulated by them
Grace Kanyanga, Executive Secretary, NGOCC	June 12, 1997	1 hour	Overview of mandate, profile of member NGOs, approach to supporting community based organizations, private sector linkages, description of HIV/AIDS projects
Margaret Matambo, UNDP	June 12, 1997	2 hours	Impact mitigation projects, UN volunteer role, Southern Province, income generation, community based home care
Nyamposa Serpell, Ph.D. Candidate, University of Maryland Baltimore	Prior to Consultancy	3 hours	Impact of HIV/AIDS on families, children, and communities
Merab Kambamu Kiremire, Program Advisor, Tasintha Daniel Mwansa, Chairperson, NCCPCF, Catholic Secretariat Rose Kakompe, Program Coord., Community Youth Center Louis Mwena, Liaison Officer, CHIN Doris Mutunwa, A/Deputy Director, MCDSS Lubinda Tafira, Exec Director, Family Life Movement Monica G. Shinkanga, Exec. Director, Community Youth Center Justina Moonga, Member, ZARD Maria Nkunika, Exec Coord, Steadfast Action Foundation James Sulwe, Consultant Florence Shakafuswa, Counsellor, YWCA Outreach Deborah Bickel, Director, PCI Thomas Goliber, Senior fellow, The Futures Group, Intl.. Robie Siamwiza, Policy Advisor, NASTLP/PCI Judge Alphonse Kamanzi, Senior Research Fellow, Zambia Law Development Committee	June 12	2 hours	Focus Group following presentation by Hunter

APPENDIX 2
LIST OF REFERENCES

CARE International in Zambia, 1996, “A Framework for Programming” and “Project Briefs”.

CHIN, Annual and Quarterly Reports, 1996 and 1997, 1997 work program.

CINDI, 1997, Activities Report, 1996.

Chela, C.M., R. Msiska, M. Sichone, and B. Mwiinga, 1994, Cost and Impact of Home-Based Care for People Living with HIV/AIDS in Zambia, Ministry of Health and Global Programme on AIDS, Geneva: WHO.

Foster, S., No Date, “Cost and Burden of AIDS on the Zambian Health Care System: Policies to Mitigate the Impact on Health Services”, London.

Frankenberger, T.R., 1996, “Measuring Household Livelihood Security: An Approach for Reducing Absolute Poverty”, paper prepared for the Applied Anthropology Meetings, March 27-30, 1996, Baltimore, Maryland.

Fylkesnes, K., H. Brunborg, and R. Msiska, 1994, “Zambia: The Current HIV/AIDS Situation -- and Future Demographic Impact”, GMZ Ministry of Health, Lusaka.

Government of Zambia, Central Board of Health, 1997, “Establishment of the Central Board of Health”, Lusaka.

Government of Zambia, Central Board of Health, 1997, Integrated Technical Guidelines for Frontline Healthworkers, Lusaka, 1997.

Government of Zambia, Central Statistics Office, 1997, Living Conditions Monitoring Survey-I, 1996 Preliminary Report, Lusaka.

Government of Zambia, National AIDS/STD/TB and Leprosy Programme, 1996, “Food Aid in Mitigating the Impact of HIV/AIDS in Zambia: Draft Proposal to the World Food Programme (WFP), Lusaka.

Government of Zambia, National AIDS/STD/TB and Leprosy, 1996, “HIV/AIDS in Zambia: A Policy Maker’s Perspective”, Lusaka.

Government of Zambia, National AIDS/STD/TB and Leprosy, 1996, “Report of a Meeting for Chief Executives on Implementation of HIV/AIDS Programmes in the Private Sector”, Lusaka.

Government of Zambia and the United Nations System in Zambia, 1996, Prospects for Sustainable Human Development in Zambia: More Choices for Our People, Lusaka.

Hunter, S. and J. Williamson, 1997, Developing Strategies and Policies for Support of HIV/AIDS Infected and Affected Children, Washington: USAID.

Kalumba, Katele, 1997, Towards An Equity-Oriented Policy of Decentralization in Health Systems Under Conditions of Turbulence: The Case of Zambia, Discussion Paper No. 6, Forum on Health Sector Reform, World Health Organization, Geneva.

Macwan'gi, M., M. Sichone, and P. Kamanga, 1996, Women and AIDS in Zambia: Situation analysis and Options for HIV/AIDS Survival Assistance, NASTLP, Lusaka.

Mano Consultancy Services, 1996, "Final Report, Pilot Anti-AIDS Campaign for Farm Workers, Mazabuka District, Lusaka: Zambia National Farmers Union and UNICEF/Lusaka.

McKerrow, N.H., 1996, "Responses to Orphaned Children: A Review of the Current situation in the Copperbelt and Southern Provinces of Zambia", UNICEF, Lusaka.

McKerrow, N.H., 1996, "Implementation Strategies for the Development of Models of Care for Orphaned Children", UNICEF Lusaka.

Mulenga, C., J. Kamwanga, and J. Ngwisha, 1993, "Orphans, Widows and Widowers in Zambia: A Situation Analysis and Options for HIV/AIDS Survival Assistance", Institute for African Studies, University of Zambia, Lusaka.

Nangawe, E., 1997, "Community Partnership in Health: Framework for Working Guidelines", Working Draft for Central Board of Health, Lusaka.

No author, 1997, "Consultancy to Determine Criteria and Structure for Public Welfare Assistance Scheme: Progress Report", from Ministry of Community Development and Social Services.

No author, 1997, "PWAs Guidelines", from Robie Siamwiza, Project Concern International.

Operation Kidzlove, 1996, Objectives and Background, Lusaka.

Poulter, C., 1996, "Review of Demographic Characteristics of Patients of a Home Based Care Team", paper presented to the Xith International Conference on AIDS, Vancouver.

Project Concern International, 1997, "Report on the Kitwe District Building Workshop on HIV/AIDS/STD/TB Held on 15-16 April, 1997,"; list of participating NGOs and CBOs with programs for families affected by AIDS in 6 districts of operation, statement of project goals and objectives.

Rossi, M. And P. Reijer, 1995, "Prevalence of Orphans and Their Education Status in Nkwazi Compound, Ndola", paper presented at the Zambian National AIDS Network Conference, Lusaka.

Serpell, N., 1996, "Children of AIDS-Affected Zambian Families: Needs Assessment and Policy

Development, Preliminary Report”, University of Maryland, Baltimore.

Siame, D., 1996, “AIDS and Development: The Salvation Army Zambia and Malawi Territory’s Response to the AIDS Crisis, Chikankata, Zambia.

Sichone, M., D. Mulenga, R. Msiska, and K. Fylkesnes, 1996, “Care of Chronically Ill/HIV Disease at Home: Adequacy of Coping Capacities and Support Needs in Selected Zambian Communities”, NASTLP, Lusaka.

Stanecki, K. and P. Way, 1997, “The Demographic Impacts of HIV/AIDS--Perspectives from the World Population Profile: 1996”, US Bureau of the Census, International Programs Center Population Division, IPC Staff Paper No. 86, March, 1997.

UNAIDS, 1996, “Facts About UNAIDS: UNAIDS-An Overview and UNAIDS in Individual Countries”, UNAIDS, Geneva.

UNAIDS, 1996, “The United Nations (UNAIDS) Support Strategy for the Zambia National HIV/AIDS Programme, 1997-1998”, Lusaka.

UNAIDS, 1996, “The Support of UN Agencies to the Second Medium Term Plan of the Zambian National AIDS/STD/TB and Leprosy Programme (NASTLP), 1994-1996”, Draft, Lusaka.

UNICEF, 1994, Action for Children Affected by AIDS: Programme Profiles and Lessons Learned, New York, UNICEF.

UNICEF/Lusaka, 1996, “HIV/AIDs in Zambia and UNICEF’s Response”, UNICEF, Lusaka.

UNICEF/Zambia, 1997, “Making a Difference for Zambia’s Children: Country Programme Management Plan 1997, UNICEF/Zambia”, January, 1997, Lusaka.

UNICEF/Zambia, 1997, “Master Plan of Operations and Programme Plans of Operations for a Programme of Cooperation Between the Government of the Republic of Zambia and UNICEF for the Children and Women of Zambia 1997-2001”, March, 1997, Lusaka.

USAID, Lusaka, 1997, “Zambia Integrated Health Package (ZHIP)”, Draft 2, 21 March, 1997, Lusaka.

Webb, D., 1996, “The Socio-Economic Impact of HIV/AIDS in Zambia”, SafAIDS News, December, 1996, Vol. 4, No. 4.

Webb, D., 1997, “The Sexual and Economic Politics of Reintegration: HIV/AIDS and the Question of Stability in Southern Africa”, in Simon, D., Ed., Reconfiguring the Region: South Africa and Southern Africa, London.

Webb, D., and G. Nkamba 1997, "Profile of Households Affected by Early Adult Mortality in Lusaka, Zambia", Draft, Lusaka.

Richard Woodroffe & Associates, 1996, Economic Expansion in Outlying Areas: Report on the Katongo Kapala PRA", 29 February to 2 March, 1996, Lusaka.

Zambian National Farmers' Union, 1996, "Broadening AIDS Education in the Agricultural Sector: A Proposal to UNICEF", Lusaka.